HCBS Waivers' Quality Improvement System File Review Instructions

General Information about the file review indicators and questions:

CMS Waiver Sub-Assurances and Waiver Performance measures are listed prior to the applicable file review indicators.

Information for some indicators will be automatically filled in by CONNECT, so it's **very** important all CONNECT forms (i.e., worksheet, LOC) exist and information is entered correctly!

Some indicators in the file reviews utilize dates that are filled in by CONNECT. These dates will be filled in when the review is put in 'edit mode' for the first time by the reviewer.

If a Section A file review for a child is opened in the 'view' mode, it will look like a review for an adult. After the review has been put in 'edit' mode, the children's information will appear in the review.

Reviewers shouldn't read things into questions that aren't written in the question.

- Example: If a question asks if something is in the Plan of Services and Supports (POSS), the question is only referring to the POSS, not narratives, assessment, etc., even if the information can be located in those other places.

Comments Sections are listed for each indicator and should include:

- **Rationales for any 'no' responses.**
  - Rationales will aid in determining appropriate remediation activities.
- Comments regarding any problems found that are related to the question, and are not covered by the question.
- Any other applicable comments by the reviewer.

Strengths Sections are listed for each indicator and should include:

- Exemplary SC/RD activities.

Remediation sections are included for all indicators.

- After all file review questions have been answered and the file review has been submitted, remediation action options will be listed for each indicator that has been scored 'no'.
- Remediation options denoted with an asterisk (*****) **cannot be used alone**. A non-asterisk option will also need to be used.
- If **'other'** is used as a remediation option, a **description of the option must be given** on the file review form.
- Remediation is to be completed within 45 days of the day the review has been 'submitted to Central Office'. If remediation is **not** completed within 45 days, the **reason for the delay must be given** on the file review form.

Instructions are not given for each question. Where possible, the HCBS Unit designed questions so instructional information is contained within the indicator or question. Also, some questions will be automatically answered by CONNECT, minimizing the need for instructions.

Text that is ***bold faced and italicized*** in this document is the text the reviewer will see on the ***CONNECT file review form***.

Section A (Client Review)

Section A Heading:

HCBS Waivers' QA File Review Section A

Type of Review:
Date of Review:

File Review #:
Client's Name: ***Client ID:*** ***Waiver Type:***
Services Coordinator: ***Program Type:***

(All information in the heading section will be filled in by CONNECT. If information in this section appears to be incorrect, please contact the HCBS Unit prior to starting the file review.)

OA: Services Authorized for:

Adult/Aged Review:
Assisted Living
Adult Day Health Care
Chore
Home Again
Home Delivered Meals
Independence Skills Management
Nutrition
Personal Emergency Response System (PERS)
Respite
Non-Medical Transportation/Escort

Children's Review:
Childcare
Independence Skills Management
Nutrition
Respite
Non-Medical Transportation/Escort

Things to remember when completing this section:

- The reviewer will check each authorized service on the CONNECT file review form.
- The reviewer will need to review each service to make sure it has been authorized.
- The reviewer will need to use N-FOCUS authorizations for in-home services and the CONNECT 'Prior Authorization for Assisted Living Waiver Service' for Assisted Living services.

Section A. *1. Eligibility Period*

Things to remember when completing this section:

- There is no sub-assurance or performance measure for this section.
- CONNECT will make initial vs. ongoing file review determinations based on the date the reviewer puts the review in the 'edit mode' for the first time. This will be based on the following definitions, which can also be found in the CONNECT manual:
  - **Initial File:** the first year of waiver eligibility determination OR a case re-opened for waiver after the case has been closed and a new referral date is in place.
  - **Ongoing File:** Completion of at least one annual review and continuing to receive on-going service provision.
- Dates used in this section will be found in the information on the CONNECT Waiver Case page. These dates will be automatically filled in by CONNECT, so it's **very** important the SC's refer to the CONNECT manual to ensure dates are entered correctly.

Initial File:

CONNECT Waiver Points of Eligibility:
(CONNECT will automatically fill in each date.)

Date of Medicaid eligibility status determination:
(CONNECT 'Medicaid Eligibility Status' section, 'Opened' date)
Date of Level of Care Determination:
(CONNECT 'Initial Assessment date')
Date of Opened Waiver Eligibility Status:
(CONNECT 'Waiver Eligibility Status' section, 'Opened' date)
Date of Level of Care Certification (for Children only)
(LOC approval date, Section 8 on form)
Date of Waiver Worksheet Eligibility Period
(CONNECT Waiver Worksheet 'Eligibility Period')

1A. Was the current Waiver Worksheet eligibility period determined correctly?

Were the waiver eligibility points determined before the Waiver Worksheet eligibility start date?
Y N

Does the Waiver Worksheet eligibility period cover a time period that does not exceed 12 months?
Y N

Ongoing File:

End date of Previous Year's Worksheet eligibility period:
(Will be automatically filled in by CONNECT from the previous year's Waiver worksheet.)
Begin Date of Current Year's Waiver Worksheet eligibility period:
(Will be automatically filled in by CONNECT from the current or last Waiver worksheet.)
End Date of Current Year's Waiver Worksheet eligibility period:

(Will be automatically filled in by CONNECT from the current or last Waiver worksheet.)

General things to remember:

- A new worksheet is needed for each new eligibility period.

1A. Was the current Waiver Worksheet eligibility period determined correctly?

Does the current waiver eligibility year, begin the first day of the month following the previous end date?
Y N

Things to remember when scoring this question:

- Reviewers should refer to information given in the Title 480 Forms Appendix (480-000-13) regarding eligibility periods.

Does the waiver eligibility period cover 12 or less calendar months?
Y N

***Remediation Action* Options for Indicator 1A:**
Develop new Waiver Worksheet with correct eligibility year
Referral to Program Integrity for claims recovery*
Individual coaching*
SC waiver policy and procedure training*
Other (describe):

Section A. *2. Functional Criteria*

Applicable Waiver Sub-Assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.
Applicable Waiver Performance Measure: Number and percent of initial and annual Level of Care (LOC) determinations made in which LOC criteria were accurately applied.

Section 02. (Assessment areas and sub-areas where the CONNECT Functional Criteria/Level of Care indicates a limitation exists.)

- Reviewers won't need to enter anything here.
- Limitations/needs from the CONNECT Functional Criteria (MILTC-14AD) or Child/Client's Level of Care (MILTC-13AD) will be automatically filled in by CONNECT and will be listed in this section of the file review.

2A. Were the functional criteria accurately applied in the LOC determination?

Is there evidence/justification/rationale in the current CONNECT FC/LOC to support each limitation checked above?
Y N

Things to remember when scoring this question:

- If a limitation is noted, something needs to be written in the justification/comments section for the limitation when required.
- Written information needs to fit the definition of the limitation.
- The reviewer needs to look at whether the client has the limitation, not the degree of limitation.
- A **'no'** should **not** be scored because there is a problem with the degree of the limitation. If there is a problem with the degree of the limitation, comments should be made in the comments section and the issue should be worked out between Supervisor and SC.
- A **'no'** should be scored if the LOC scoring indicates a limitation exists, and the client is independent.
- If the review is for a client receiving services from the TBI Waiver, the reviewer needs to make sure the file contains a medical diagnosis of a traumatic brain injury which is defined as traumatically acquired non-degenerative structural brain damage.

If there is other information in the file, does it also support the evidence/justification/rationale in the current CONNECT FC/LOC?
Y N NA

Things to remember when scoring this question:

- Reviewers may need to review the assessment, POSS and narratives before answering this question.

(For Children's Review only) ***Has the most current CONNECT LOC document been certified by HCBS Waiver Unit?***
Y N

Things to remember when scoring this question:

- LOC needs to have been approved by the HCBS Unit nurse.
- 'Current' means the most recent LOC in CONNECT.

***Remediation Action* Options for Indicator 2A:**

Re-determination and the assessment categories meet criteria.
Re-determination and the assessment categories do not meet criteria.
Re-determination and client/child does not meet level of care (HHS-6 sent and case closed).
Referral to Program Integrity for claims recovery*
Individual coaching*
SC waiver policy and procedure training*
Other (describe):

2B. (For HCBS Unit Review Use Only for Children's Reviews) *Does the CONNECT Functional Criteria/ Level of Care scoring support the decision regarding the determination/certification of NF level of care?*

Y N

Things to remember for this indicator:

- This item is only for HCBS Unit reviews for children and won't be included on Local Level file reviews.
- This category is important because remediation for this category has to be reported to CMS.
- This question will be used for both initial and ongoing reviews.

(For ongoing review only) ***Was the current NF level of care re-determination date prior to begin date of current eligibility period?***

Date of current year's eligibility period:
Date of Current NF level of care approval:

***Remediation Action* Options for Indicator 2B:**

Re-determination and client/child meets Nursing Facility Level of Care.
Re-determination and client/child does not meet level of care (HHS-6 sent and case closed).
Referral to Program Integrity for claims recovery*
Individual coaching*
SC waiver policy and procedure training*
Other (describe):

Applicable Waiver Sub-Assurance: Levels of Care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.
Applicable Waiver Performance Measure: Number and percent of participants whose level of care is re-determined at least annually.

***2C. (*Ongoing case only)**

Date of current year's eligibility period:

- CONNECT will automatically fill this in from the current year's Waiver worksheet.

Date of current NF level of care redetermination:

- CONNECT will automatically fill this in from current year's NF LOC
  - Section 7 will be used for children
  - 'Determination date and Certification Summary' will be used for Adult/Aged.

Was the current NF level of care redetermination date prior to begin date of current eligibility period?
Y N

Things to remember when scoring this question:

- CONNECT will automatically fill in the answer to this question.

***Remediation Action* Options for Indicator 2C:**

LOC Re-determination and client/child meets criteria.
LOC Re-determination and client/child does not meet level of care (HHS-6 sent and case closed).
Referral to Program Integrity for claims recovery*
Individual coaching
SC waiver policy and procedure training
Other

Section A. *3. Needs Assessment*

Applicable Waiver Sub-Assurance: The State monitors service plan development in accordance with its policies and procedures.
Applicable Waiver Performance Measure: Number and percent of participants for whom a current needs assessment has been completed.

03. Check if the individualized need assessment section is filled out. Check and list if assessment indicates an identified need/s.

Things to remember when completing this section:

- The CONNECT file review form will display all sections of the appropriate needs assessment.
  - MILTC-2AD for adults/aged
    - Support
    - Health Status
    - Medications/Equipment
    - Nutrition
    - IADL's
    - Housing
  - MILTC-7AD for children
    - General Medical Information
    - Daily Living Activities
    - Equipment/Supplies
    - Support Services
    - Physical Environment
    - Requests
  - EI-1 for EDN
    - Concerns/Priorities page (e.g. respite, child care, nutrition, ATP)
    - Child's Present Levels of Development (e.g. vision, hearing, health status, cognitive/thinking, communication, social/behavioral, self-help/adaptive, fine motor and gross motor skills)
- 2 things will be scored for each section of the assessment.
  - Is each section of the needs assessment filled out?
  - Which sections of the needs assessment have identified needs?
- ***Check if the individualized need assessment section is filled out.***
  - The reviewer will enter yes/no to indicate whether or not the specific section of the assessment form is filled out. (The identifying information section of the assessment will not be included in the review.)
  - **Assessment form sections will be considered to be 'filled out' if:**
    - Every question related to planning purposes is answered.
    - The section does not contain information that is contradictory to other information within the file. (Example: Information indicates a walker is used, but walker is not checked in the equipment list. Thus, the 'Medications/Equipment' section of the adult/aged assessment would be scored 'no'.)
    - (For Adult/Aged population) If a question on the assessment is answered **'yes'**, indicating there's a need, supportive information must be written in the

appropriate box/blank/care plan note area on the assessment form.

- ***Check and list if the assessment indicates an identified need.***
  - The reviewer will enter yes/no to indicate whether or not there was an identified need for each section of the assessment.
  - If a need was identified in a section, the reviewer will need to list the identified need in the text box for that section.
  - CONNECT will automatically add any needs checked 'yes' to Indicator 4C.
- Since the needs assessment isn't in CONNECT, this information will need to be entered by the reviewer.
- This information will be used for indicator 3A which measures completion of the needs assessment tool.

3A. Is the current individualized needs assessment filled out on the required form (MILTC-2AD or MILTC-7AD or EI-1)?

Y N

Things to remember when completing this item:

- CONNECT will automatically answer this indicator from the information entered in Section 03.

***Remediation Action* Options for Indicator 3A:**

Needs assessment filled out on required form.
Individual coaching*
SC waiver policy and procedure training*
Other (describe):

3B. If a client has a guardian, is he/she involved in verifying the assessment information as indicated on the assessment or in the narrative?

Y N NA

Things to remember when scoring this indicator:

- This indicator will only be scored if the client has been appointed a legal guardian by the court.
  - Score **'NA'** if the client **does not have a guardian or is a minor child**.
- Guardians need to verify the information received during the assessment process is valid. The following situations would be evidence of the guardian's involvement:
  - Information in the 'others present' section of the assessment or the narrative indicates the guardian's participation, either in person or by telephone.
  - Information indicates a copy of the assessment was sent to the guardian.

***Remediation Action* Options for Indicator 3B:**

Needs assessment verified by legal guardian.
Individual coaching*
SC waiver policy and procedure training*
Other (describe):

***3C.* (Ongoing Case)**
Date of current needs assessment:
(Reviewers will need to fill in this date.)
Current eligibility year start date:
(This will be automatically filled in by CONNECT.)
Current eligibility year end date:
(This will be automatically filled in by CONNECT.)

Was the current individualized needs assessment completed on/before the start of the current eligibility period?
Y N

Things to remember for this indicator:

- The only thing the reviewer needs to enter for this indicator is the 'date of current needs assessment' (above). CONNECT will automatically fill in the answer to this indicator.
- Reviewers will refer to the following to determine the 'date of current needs assessment':
  - Adults/Aged: 'Date of Assessment' on the current needs assessment (MILTC-2AD).
  - Children: 'Date of interview' on the current needs assessment (MILTC-7AD).
  - EDN: Date the parent/SC meet and draft Pre-IFSP cover page, 'Family's Concerns and Desired Priorities' page, 'Child and Family's Strengths' page, and 'Child's Present Levels of Development' page of IFSP.
- If the assessment is conducted over multiple days, the date the assessment is completed will be the date that will be entered.

***Remediation Action* Options for Indicator 3C:**

Reassessment (if the assessment was not current at the time of review)
Individual coaching
SC waiver policy and procedure training
Other

Section A. *4. Plan of Services and Supports*

Applicable Waiver Sub-Assurance: The State monitors service plan development in accordance with its policies and procedures.
Applicable Waiver Performance Measure: Number and percent of participants whose Plans of Services and Supports were developed in accordance with State policies and procedures.

4A. Does the File contain a current individualized Plan of Services and Supports (POSS) (MILTC-12AD or IFSP for EDN)?
Y N

Things to remember when scoring this question:

- This question is measuring whether or not the file contains the correct DHHS/EDN form, **not** whether or not the form has been completed correctly.
- This indicator refers to an 'individualized' plan. Subsequent indicators will address whether or not the plan is 'individualized'.

Date current POSS developed:
(Reviewer will need to fill in this date.)
Current eligibility year start date:
(This is for an ongoing file review and will be automatically filled in by CONNECT.)
Current eligibility year end date:
(This is for an ongoing file review will be automatically filled in by CONNECT.)
Date of initial service authorization:
(This is used for an initial file review and will need to be filled in by reviewer.)

(For initial review) ***Was the POSS developed on or before initial services authorization date?***
Y N
(Ongoing review) ***Is the date of the current POSS on or before the start of the current eligibility period?***
Y N

Things to remember when scoring these questions:

- The reviewer will use the N-FOCUS authorizations for in-home services and the CONNECT authorization for AL services when entering initial service authorization date for initial file review.
- The reviewer will enter the needed dates. CONNECT will automatically fill in the answer.

***Remediation Action* Options for Indicator 4A:**

POSS developed and in file
POSS updated/revised
Individual coaching*
SC waiver policy and procedure training*
Other (describe):

4B. Does the POSS indicate the client/legal representative was involved in the development of the individualized POSS?

General things to remember for this indicator:

- For this indicator, **legal representative** refers to a person who has legal standing to make decisions on behalf of another person.
  - Guardian appointed by court
  - POA granted by person
- If there is a legal guardian or a parent of an minor child, the **legal guardian or parent must be involved** with the development of the POSS.

Were the client/legal representative/family's strengths, concerns, preferences, and priorities addressed in the POSS?
Y N

Did the client/legal representative indicate involvement with the individualized POSS by signing the individualized POSS?
Y N

General things to remember when scoring this question:

- If the client has a legal guardian who has participated in the POSS meeting via telephone or other electronic process and the POSS has not been signed by the guardian, a 'yes' will be scored if the SC has written the following (or similar) statement on the signature line of the POSS; "Guardian participated by method on date; POSS mailed date."
- This question relates to the "Client's Plan of Service and Supports Review" section of the POSS. Do not score a "no" if this section has been signed, and the "Provider Choice" section has not been signed.

***Remediation Action* Options for Indicator 4B:**

Client/family concerns/suggestions were added to the POSS
Client/legal representative signs POSS
Individual coaching*
SC waiver policy and procedure training*
Other (describe):

Applicable Waiver Sub-Assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.
Applicable Waiver Performance Measure: Number and percent of participants for whom all assessed needs (including health and safety risk factors) have been addressed in the Plan of Services and Supports (POSS).

4C. Does the client's POSS address all assessed needs, including health and safety risk factors, as identified in the assessment and functional criteria/level of care?

Things to remember when scoring this indicator:

- The LOC needs identified in Section 2 (02) and the needs identified in the needs assessment from Section 3 (03) will be displayed in the CONNECT file review form.
- For each need listed, the reviewer will check yes/no to indicate:
  - Whether or not there was an individualized outcome for the need.
    - Outcomes may cover more than one need.
  - Whether or not the outcome had corresponding action steps which address the need.
    - Action steps may cover more than one need.
- After the reviewer has scored the outcome and action steps sections for each listed need, CONNECT will automatically fill in the answers to the indicator/questions.
- Reviewers should base their rating on the information currently listed in the assessment, not in the narrative or other parts of the file. This item looks at the **development of the POSS**, not whether the assessment was done correctly.
- This indicator addresses whether or not the outcome/action step addresses the need. It's **not** meant to measure the quality of the outcome/action step.
- Action steps are further addressed in Indicator 4E.
- This indicator is important because of the purpose of the waiver. Clients' needs must be identified and services in place to meet those needs so that they can remain safely in their homes and communities.
- Equipment needs listed in the needs assessment need to be listed/specified in action step(s) if the equipment is needed for the client's safety. If equipment is listed, and not needed for the client's safety, a general action step may be used.
- Emergency Response System's (ERS) are provided in Assisted Living Facilities per regulation. If the client resides in an ALF, the ERS does not need to be included in an action step unless there is a specific usage or safety issue for the client.
- If there is a bathing deficit, the action step addressing this deficit needs to address frequency of bathing. Otherwise, frequency does not need to be addressed on action steps. Frequency is addressed on the Waiver Worksheet.

Does the client's POSS have individualized outcome statements which address all assessed needs, including health and safety risk factors, as identified in the assessment and functional criteria/level of care?
Y N

Do all outcome statements contained in the client's POSS have corresponding action steps which appropriately address all assessed needs, including health and safety risk factors, as identified in the assessment and functional criteria/level of care?
Y N

***Remediation Action* Options for Indicator 4C:**

Outcome statements to address all assessed needs are added to the POSS
Action steps to address all assessed needs are added to the POSS.
Individual coaching*
SC waiver policy and procedure training*
Other (describe):

Applicable Waiver Performance Measure: Number and percent of participants for whom all assessed personal goals have been addressed in the POSS.

4D. Does the individualized POSS address all assessed personal goals, such as community integration, relationships, employment, income and savings, health care and wellness, education and others?

General things to remember:

- CMS places importance on personal goals as evidenced by this sub-assurance.
- This indicator was worded to include examples of personal goals.

Do narratives contain information that indicates there are personal goals in addition to those assessed in the Needs Assessment?
Y N
(If answer is yes, continue to next question. If answer is no, indicator is NA.)

Does the POSS address these additional personal goals?
Y N

***Remediation Action* Options for Indicator 4D:**

Outcome statements were added which address personal goals
Action steps were added which include interventions to address personal goals
Individual coaching*
SC waiver policy and procedure training*
Other (describe):

4E. Does the individualized POSS have action steps that are adequate to address the client's outcomes?

General things to remember for this indicator:

- This is where the specifics of the action steps are addressed.
- The following questions are based on CMS expectations for person-centered plans.

Do the action steps identify- informal parties (e.g., family, community individuals) responsible to support the outcome?
Y N

General things to remember when scoring this question:

- Specific family names don't need to be listed, can just list 'family'.

Is the client identified when they are expected to participate in supporting their outcome?
Y N

General things to remember when scoring this question:

- Clients **ARE** expected to participate in supporting their outcomes, so they should at least

be listed in some steps, including children, as applicable.

Do the action steps identify formal parties (e.g., paid providers, Services Coordinator, healthcare providers) responsible to support the outcome?
Y N

General things to remember when scoring this question:

- Provider names don't need to be listed. It's OK if just 'provider' or the agency name is listed.

Do the action steps include waiver and non-waiver services?
Y N

General things to remember when scoring this question:

- 'Non-waiver services' is broader than non-waiver Medicaid services.
- Reviewers should keep in mind the POSS **does** need to have non-waiver services including access to health services (e.g., dentist, podiatrist).

***Remediation Action* Options for Indicator 4E:**

Informal parties were identified
Formal parties were identified
Client was identified
Identify waiver/non-waiver services on the POSS
Individual coaching*
SC waiver policy and procedure training*
Other (describe):

4F. Does the individualized POSS ensure the safety of the client based on the results of the functional criteria/level of care and needs assessment?

General things to remember for this indicator:

- The POSS must ensure the client's health and welfare, including strategies to mitigate identified risks.
- If such a POSS can't be developed, the client is not eligible for this waiver.
- Reviewers should keep in mind CMS states the presence of risks does not mean the client should not be offered waiver services, or they should not have decision making authority over their services. The Services Coordinator should work with the client/client representative/family to come up with appropriate interventions that would reduce the risk.

Does the POSS address all identified health and safety risks with sufficient supports and interventions to prevent harm to the individual?
Y N

Things to remember when scoring this question:

- Risk factors are issues which cause significant impact to the person's life and functional

capacity. To be considered a factor, the risk must be immediate and require a significant intervention (referral, support, or service), either in a facility or as part of an in-home plan.
- This question is different than 4 C and 4E. Here, the question is measuring whether the identified risks had appropriate strategies and supports and how effective they were to mitigate risks in order to ensure the client's health and welfare.

Does the POSS back-up plan, based on the client's individual needs, address situations of the unavailability of a provider or informal support; or in the event of a natural disaster/emergency?
Y N

Things to remember when scoring this question:
- The HCBS Unit used to refer to separate back up (unavailability of provider) and disaster plans. Both issues are now included in the back up plan.
- Reviewers should keep in mind the back up plans still need to be individualized, so back up plans won't all be the same.
  - Examples - Loss of electricity is different for a person with a ventilator than for a person without a ventilator. A client may not want a back up provider.
- Back up plans need to be in POSS.
- If the client resides in an Assisted Living Facility, unavailability of a provider does not need to be addressed in the back up plan.
- If there is not a risk/need for a back up plan, that needs to be documented in the POSS, NOT the narrative.
  - HCBS Unit is requiring the back up plan to be on POSS based on CMS assurance.
- There should be action steps concerning coverage/safety, so the lack of need for a back up plan can be included as part of those action steps.

***Remediation Action* Options for Indicator 4F:**

Updated/revised POSS to ensure safety of client
If updated/revised POSS does not ensure client safety, HHS-6 to close case sent to client
Back-up Plan addressed on POSS
Individual coaching*
SC waiver policy and procedure training*
Other (describe):

Applicable Waiver Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.
Applicable Waiver Performance Measure: Number and percent of participants whose Plans of Services and Supports (POSS) were revised, as needed, to address changing needs.

4G. Does the file indicate the client's POSS was updated when care needs changed?

Note: Substantial change would be indicated if the person requires additional waiver or non-waiver supports or the person no longer needs currently planned supports requiring a change in the POSS. This may occur due to a change in the person's support system or the person's needs as identified in the functional criteria/level of care.

Were additional supports identified or were current supports no longer being utilized?
Y N

Things to remember when scoring this question:

- To determine if additional supports were identified or were no longer being used, reviewers will need to look at LOC/Functional Criteria, Needs Assessment and narratives for current file review period.
- If the answer to this question is 'Yes', additional questions will appear for the reviewer to answer.
- If the answer to this question is 'No', the question indicator will be automatically scored 'NA' and the reviewer will not answer any additional questions for this indicator.

Was the current POSS form updated if required?
Y N

Things to remember when scoring this question:

- Even though reviewers will need to look at LOC/Functional Criteria and Needs Assessment to determine if there was a need change, this question is **NOT** about the LOC and assessment, it's **JUST about the POSS.**
- If this question is scored 'Yes', an additional question will appear for the reviewer to answer.
- If the answer to this question is 'No', the additional question will not appear and the indicator will automatically be scored 'No'.

Were the updates dated?
Y N

Things to remember when scoring this question:

- If an action step was added, the date it was added should be documented on the POSS.
- If an action step was completed because services were no longer needed and the date it was completed is not documented on the POSS, a 'yes' would be scored if the date is documented in the narrative.

Remediation Action **Options for Indicator 4G:**

Revise POSS to include updates with appropriate supports
Revise POSS to include dates
Individual coaching*
SC waiver policy and procedure training*
Other (describe):

4H. Does the file contain a Prior Authorization for Assisted Living Service (MC-9AD) completed correctly?

Things to remember for this indicator:

- This question is only for Assisted Living services, it won't show up on the in-home services

review.

- Reviewers will need to refer to the AL authorization in CONNECT.
- Reviewers will need to refer to Waiver Assisted Living Rate Chart which is posted on the DHHS website.

Is the rural/urban portion of the level code correct?
Y N

Is the single/multiple portion of the level code correct?
Y N

If multiple, is the Client Consent for Multiple Occupancy form (MILTC-21) in the file?
Y N NA

***Remediation Action* Options for Indicator 4H:**

Revise/complete Prior Authorization
Complete multiple occupancy form
Refer to Program Integrity for claims recovery*
Individual coaching*
SC waiver policy and procedure training*
Other (describe):

Section A. *5. Waiver Worksheet*

Applicable Waiver Sub-Assurance: Services are delivered in accordance with the service plan including the type, scope, amount, duration and frequency specified in the service plan.
Applicable Waiver Performance Measure: Number and percent of participants whose Plans of Services and Supports (POSS) indicated services were delivered in accordance with the POSS.

5A. Does the current Waiver Worksheet identify the type, amount, duration and frequency of Medicaid and Waiver Services?

General things to remember:

- This item is only for Medicaid and Waiver Services**. If there are other services (e.g. Medicare), don't look at those for the purpose of scoring this indicator.**
  - Reviewers should refer to the CONNECT version of the waiver worksheet, **NOT** the printed PDF of the worksheet as applicable service notes will not appear on the PDF version.

Does CONNECT includes a Waiver Worksheet for the most current eligibility period?
Y N

Things to remember when scoring this question:

- For purposes of the file review, the eligibility period is covered in Section 1. This question is about whether or not the worksheet for the most current eligibility period exists in CONNECT.

Does the Waiver Worksheet include all the Medicaid (e.g. Home Health, PAS, and Medical Transportation Medicaid authorized services) and Waiver Services as identified on the POSS action steps?
Y N

Things to remember when scoring this question:

- Services on Waiver Worksheet need to match both POSS action steps and authorizations.
- Reviewers will need to check authorizations in C-1, Job 31 to ensure that authorized Medicaid non-Waiver services are included.

Does the Waiver Worksheet identify the services type, provider type/name, #service units or frequencies, beginning and end dates and the amount of services duration and needed frequency?
Y N

Things to remember when scoring this question:

- These need to be included for **all** services. If one is wrong, the answer to this question is 'no'.
- Rates are not included in this question. The reviewer should not score a "no" if the rate is incorrect, but should make a comment.
- Clarification: The Waiver Worksheet doesn't need to have both the provider type and the

provider name. It just needs to have one or the other.

***Remediation Action* Options for Indicator 5A:**

Waiver Worksheet updated/revised
Individual coaching*
SC waiver policy and procedure training*
Other (describe):

Section A. *6. Valid Consent/Choice*

Applicable Waiver Sub-Assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.
Applicable Waiver Performance Measure: Number and percent of participants whose file contains a completed and signed consent form indicating choice between institution care and waiver services.

6A. Does the file contain a valid Consent Form (MILTC-5AD) that verifies that the client/legal guardian chose between HCBS and Nursing Facility?

General things to remember for this indicator:

- If client has a legal guardian, the **legal guardian must sign the consent**, although the client should also sign, if possible.
    - **This would include the parent of a child.**
- **If the legal guardian changes because of age or other reason, a new consent needs to be signed.**
- **If the client does not have a legal guardian, the consent must be signed by the client. The signature of a Power of Attorney or spouse can not take the place of the signature of the client or legal guardian.**
- If the client is unable to sign the consent, the client may make his/her "mark" or use a stamp. This will need to be witnessed.

Does the consent signed by the client/legal guardian document that the client/legal guardian chose between HCBS and Nursing facility services?
Y N

Things to remember when scoring this question:

- The box on the consent which signifies the choice between HCBS/community services and nursing facility services needs to be checked.

Was the consent signed by the client or current legal guardian?
Y N

Was the consent dated before the current file review?
Y N

Things to remember when scoring this question:

- The reviewer will score "yes" or "no" based on the date the reviewer does the file review.

***Remediation Action* Options for Indicator 6A:**

SC has client/legal guardian complete consent form
Individual coaching*
SC waiver policy and procedure training*
Other (describe):

Applicable Waiver Performance Measure: Number and percent of participants whose files indicated participants chose among types of services.

6B. Does the file document that information was made available to the client that the client/family can choose among service options?

Y N

Things to remember when scoring this indicator:

- CMS is interested in how participants are informed of services available under the waiver.
- To determine this, the reviewer will need to use the current year's narratives and the consent form.
- If the box on the consent which indicates understanding of the right to choose services is not checked, a **'No'** would be scored for this item, even if the consent was signed and dated.

***Remediation Action* Options for Indicator 6B:**

SC has client/legal guardian complete consent/choice form
Individual coaching*
SC waiver policy and procedure training*
Other (describe):

Applicable Performance Measure: Number and percent of participants whose files indicated participants chose among providers.

6C. Does the file indicate that information and support was available to help the client/legal representative make informed decisions among service providers?

Does the file or POSS document that the client chose among qualified providers?

Y N

Things to remember when scoring this question:

- If the client or legal representative has not signed "2. Provider Choice" in "Section 3: Signatures" on the POSS, a 'no' should be scored.

If the provider is the Services Coordination agency, is the conflict of interest (MILTC-61) present and signed by the client/legal representative?

Y N NA

Things to remember when scoring this question:

- This question is only needed if the SC Agency is the provider of a service authorized for the client.

***Remediation Action* Options for Indicator 6C:**

Provider Options documented

SC has client/legal guardian complete consent/choice form
SC has client/legal representative complete conflict of interest form (MILTC-61)
Individual coaching*
SC waiver policy and procedure training*
Other (describe):

6D. Does the File contain a properly completed Form IRS 2678/FA-65?

Is the client receiving in-home services by an individual provider (not agency provider)? (If Yes, proceed to next question. If no, indicator is NA.)
Y N

If yes, does the file contain a FA-65 which is completed correctly?
Y N

Things to remember when scoring this question:

- The form, FA-65 replaced the Form IRS-2678 in the fall of 2012. All files for clients who receive in-home services from an individual provider should contain this form.
- For any future versions of the FA-65/Form IRS-2678, this question will be scored 'yes' as long as the form is filled out according to the instructions as referenced in the Title 480 Forms Appendix.
- Completion of the FA-65/Form IRS-2678 is not a CMS requirement. It is an IRS requirement. It assigns DHHS as the agent of the client for employer purposes.

***Remediation Action* Options for Indicator 6D:**

SC has client/current legal guardian correct the IRS 2678 Form
Individual coaching*
SC waiver policy and procedure training*
Other (describe):

Applicable Waiver Performance Measure: Number and percent of participants who received information/education about how to report abuse, neglect, or exploitation.

6E. Does the file indicate that the client received information/education about how to report abuse, neglect or exploitation?

Does the file document that the client received information about how to report abuse, neglect or exploitation?

Y N

Things to remember for this indicator:

- The signed copy of the consent must include **both** the signed front page and the back page that contains the information about reporting abuse, neglect or exploitation.

- If the 2nd page of the consent is not in the file, the evidence the client received the information may be found in the narrative, and the narrative **must specifically** document one of the following situations:
    - A copy of the second page or both pages of the consent was given to the client/guardian.
    - The hotline phone number was given to the client/guardian.
- This information may also be found in an action step on the POSS.

Remediation Action **Options for Indicator 6E:**

SC reviews with client how to report abuse and has client/legal guardian sign consent/choice form
SC files consent/choice client right's page
SC narrative documents client received information as to how to report abuse
Individual coaching*
SC waiver policy and procedure training*
Other (describe):

Section A. 7. Service Delivery Monitoring

Applicable Waiver Sub-Assurance: Services are delivered in accordance with the service plan including the type, scope, amount, duration and frequency specified in the service plan.
Applicable Waiver Performance Measure: Number and percent of participants whose Plans of Services and Supports (POSS) indicated services were delivered in accordance with the POSS.

7A. Does the file indicate monthly services coordination monitoring of the client's health and welfare along with their waiver and non-waiver service delivery?

General things to remember for this indicator:

- Information needed for this section will be in the CONNECT narratives.
- Narratives should be complete, especially since progress will no longer be documented in POSS.
- **The following questions are taken directly from regulations, so SC's will need to ensure all issues covered in these questions are covered in their narratives.**
- Remember, even though SC's need to document monitoring for all services, this does not mean that all narratives will cover each service equally. Special issues come up that will naturally require more monitoring than others.

Does the file indicate the Services Coordinator attempted to make contacts monthly?
Y N

Things to remember when scoring this question:

- This question is meant to measure whether or not the SC tried to contact the client, not whether or not the monthly contact contained all essential elements.

Does the file document the monthly monitoring of the client's health and welfare and use of waiver and non-waiver services?
Y N

Things to remember when scoring this question:

- If services are not used monthly, there needs to be documentation as to why services weren't used and how clients' needs are being met.

Does the file document the client's satisfaction with the waiver and non-waiver services received?
Y N

Does the file contain evidence of appropriate follow up to client requests/concerns?
Y N NA

***Remediation Action* Options for Indicator 7A:**

Referred to Contract Manager for possible SC billing reimbursement
Conduct additional monitoring to address issues not previously monitored
Conduct follow-up on client's request(s)
Narrative is updated to include all required monitoring activities

Client's satisfaction documented
Effectiveness of waiver services documented
Individual coaching*
SC waiver policy and procedure training*
Other (describe):

7B. Was a CONNECT incident report completed for each event known to the SC that brought harm or risk of harm to the client (e.g., abuse/neglect, exploitation or licensing violations) during the current eligibility year?

Y N NA

Things to remember when scoring this indicator:

- Reviewers should refer to narratives to determine if there was knowledge of a situation that brought harm or risk of harm to the client.
- Reviewers should refer to the State definitions of abuse/neglect.
- Reviewers should refer to N-FOCUS alerts to determine if the SC received a CPS/APS alert about a CPS/APS intake.
- **Remediation for this item needs to be as immediate as possible.**

***Remediation Action* Options for Indicator 7B:**

Made referral to appropriate agency (e.g., law enforcement, CPS/APS, Licensing)
Submit incident report
Individual coaching*
SC waiver policy and procedure training*
Other (describe):
Agency continuous improvement plan (HCBS Unit use only)

7C. Does the file document that notice of client rights was supplied with the notice of adverse action (CONNECT/N-FOCUS HHS-6)?

Were any adverse actions taken with the client?
(If Yes, proceed to next question. If no, indicator is NA.)
Y N

Was a CONNECT/N-FOCUS HHS-6 sent to the client?
Y N

Things to remember when scoring this question:

- This question is **just** looking at whether or not the HHS-6 is in CONNECT/N-FOCUS, as the notice of client's rights would be included with the HHS-6.

***Remediation Action* Options for Indicator 7C**

CONNECT HHS-6 including client rights sent to client

Individual coaching*
SC waiver policy and procedure training*
Other (describe):

Section A. 8. *Services Coordination Billing*

8A. Does the file indicate services coordination occurred during the sample month?

General things to remember for this indicator:

- The sample month will be assigned by HCBS Unit.
  - The sample month will be 3 complete months before the month of the file review.
- Reviewers will review the billing for the sample month to see if the 'place' for the billing matches the narrative for the sample month.
- If reviewing an initial file which was not open during the assigned sample month, the reviewer will choose another month and note this in the comments section.

Did the CONNECT Services Coordination billing type and place correspond with the documentation regarding Services Coordination contact in the file for the sample month?
Y N

Does the file document that the monitoring billing contact occurred with the client/legal guardian (e.g. not the paid provider)?
Y N

***Remediation Action* Options for 8A:**

Referred to Contract Manager for possible SC billing reimbursement
Agency continuous improvement plan (HCBS Unit use only)
Individual coaching*
SC waiver policy and procedure training*
Other (describe):

Section B (Provider Review)

Section B Heading:

Type of Review:

Date of Review:
Required Remediation Deadline:
File Review #:
Client's Name: ***Client ID:*** ***Waiver Type:***
Resource Developer: ***Provider:*** ***Type of Provider:***

Things to remember for this section:

- All information in the heading section will be filled in by CONNECT. If information in this section appears to be incorrect, please contact the HCBS Unit prior to starting the file review.
- The provider contract that is current at the time of the file review is the contract that will be reviewed.

Type of File:

Initial – provider first year enrollment
Ongoing – renewed provider enrollment

(The 'Type of File' section will be filled in by the reviewer. The reviewer should remember that this refers to longevity as a provider in general, not time with a specific client.)

Does the provider possess a current Nebraska license for services that require a DHHS license?

Y N NA Agency Adult Day Health Services
Y N NA Agency Assisted Living Facility
Y N NA Individual Child Care Family Child Care Home I/II or Agency Child Care Center
Y N NA Agency/Individual Nutrition (Licensed Medical Nutrition Therapist)
Y N NA Agency Respite Services

Things to remember when filling out this section:

- This section **must be completed** by the reviewer. CONNECT will not automatically fill in the information.
- A **'Yes'** will be scored if the provider needs a license and has the license.
- A **'No'** will be scored if the provider needs a license, but doesn't have the license.
- A **'NA'** will be scored if the provider does not need a license.
- The new MC-19 requires the agency to attach a copy of the license, so reviewers should refer to this when completing this section.
- The information in this section is needed due to CMS expectations.

Section B. 1. PROVIDER FILE REVIEW

Qualified Providers
Applicable Waiver Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.
Applicable Waiver Performance Measures:
Initial Provider Enrollment: Number and percent of enrolled licensed, certified providers that initially met provider standards prior to furnishing waiver services.
Initial Provider Enrollment: Number and percent of enrolled non-licensed, certified providers that initially met provider standards prior to furnishing waiver services.
On-going Provider Enrollment: Number and percent of enrolled licensed, certified providers that met provider standards at annual review.
On-going Provider Enrollment: Number and percent of enrolled non-licensed, certified providers that met provider standards at annual review.

1A. Does the file contain the required Service Provider Agreement Form and Service Provider Addendum completed correctly (MC-19 and MC-190)?

Does the file indicate the Resource Developer conducted an in-person interview?
Y N

Things to remember when scoring this question:

- This should be in either the N-FOCUS provider narrative, or the written provider narrative, **not** the client narrative.
  - If this information is in the client narrative, but not the provider narrative, a **'no'** would be scored.
- The provider narrative needs to specifically indicate that the RD met with the provider.

Does the file contain the required Service Provider Agreement Form and Addendum (MC-19 and MC-190)?
Y N

Things to remember when scoring this question:

- This question is just looking at whether or not the forms are in the file.
- Whether or not the forms are done correctly is covered in a later question.

Is the form signed/dated by both the provider and the RD?
Y N

Things to remember when scoring this question:

- The MC-19 should be signed by the provider and the MC-190 should be signed by both the RD and the provider.

Are all sections of the form completed correctly?
Y N

Things to remember when scoring this question:

- Reviewers should refer to MC-19-I (instructions) when reviewing the MC-19.
- If there is a service specific addendum in the file that is not listed on the MC-190 (Service Provision Section), the reviewer should determine that the MC-190 is not filled out correctly. A **'no'** would be scored for this item.
- The MC-19 is to be completed by the provider (not the RD) and it needs to be totally completed.

***Remediation Action Options* for Indicator 1A:**

Complete Service Provider Agreement Form
Correct errors on Service Provider Agreement Form
Individual coaching*
RD waiver policy and procedure training*
Other (describe):

1B. Does the file contain the Service Specific Addendum for each service the provider is approved to provide?

Does the file contain the service-specific addendum for each service that the provider is authorized to provide?
Y N

Things to remember when scoring this question:

- The file needs to contain a service specific addendum for **each service** listed on the MC-190.
- In this item, reviewers are only looking for the addendums listed on the MC-190.

Check the services for which there is a required service-specific addendum in the file.

Assisted Living (MC-191 AD)	***Adult Day Healthcare (MC-196)***	***Childcare (CC-0350- CC0351)***
Chore (MC-195)	***PERS (MC-193AD)***	***Home Delivered Meals (MC-197)***
Respite (MC-198)	***Transportation/Escort (MC-211)***	***Home Again (MC-194AD)***

Things to remember when scoring this section:

- Reviewers will need to fill this in. CONNECT will not automatically fill in the information.

Is the service-specific checklist completed correctly?
Y N

Things to remember when scoring this question:

- Reviewers will need to refer to the individual instructions for each addendum to determine if they are correct.

***Remediation Action Options* for Indicator 1B:**

Complete missing checklists
Correct errors on forms

Individual coaching*
RD waiver policy and procedure training*
Other (describe):

1C. Does the file contain a completed W-9/W-4?

Does the file contain a completed W-9/W-4?
Y N

Does the provider's name and tax identification number (either the SSN or FTIN), from N-FOCUS or C1 for agency providers, match exactly with the name/tax number on the W-9/W-4?
Y N

Things to remember when scoring this question:

- Reviewers should refer to instructions for completing the W-9/W-4.
- The first and last name and the Social Security number are pieces of information that need to match exactly. Do not give a 'no' if a middle initial is listed in one place, but not the other.

***Remediation Action Options* for Indicator 1C:**

Complete W-9/W4
Correct errors on form
Individual coaching*
RD waiver policy and procedure training*
Other (describe):

1D. Does the file contain evidence that the provider contract was made effective after all approvals were received?

Individual Provider: (* indicates entry by the reviewer is required)

Complete below:		
****Previous Provider Agreement End Date* (Ongoing review only)**	***Date:***	
****Criminal Background Check***	***Approval Date:***	***Approval Outcome: Y N***
****Office Inspector General (OIG)***	***Approval Date:***	***Approval Outcome: Y N***
****Excluded Party List System (EPLS)***	***Approval Date:***	***Approval Outcome: Y N***
Department Motor Vehicle (DMV) (transp. only)	***Approval Date:***	***Approval Outcome: Y N***
****Adult Protection Services (APS) Central Registry***	***Approval Date:***	***Approval Outcome: Y N***
****Child Central Register of Abuse and Neglect (CPS)***	***Approval Date:***	***Approval Outcome: Y N***
****Nebraska Sex Offender Website***	***Approval Date:***	***Approval Outcome: Y N***
License Information System (Licensed provider only)	***Approval Date:***	***Approval Outcome: Y N***
****Social Security Death Master File (SSDMF)***	***Approval Date:***	***Approval Outcome: Y N***
****Provider Agreement RD Signature Date***	***Date:***	
****Current Provider Agreement Begin Date***	***Date:***	

Agency Provider: (* indicates entry by the reviewer is required)

Complete below:		
****Previous Provider Agreement End Date*** **(Ongoing review only)**	***Date:***	
****Review of Agency policies about hiring and reporting regarding abuse/neglect and criminal background***	***Approval Date:***	***Approval Outcome: Y N***
****Review of Felony/Misdemeanor Statement (MC-199)***	***Approval Date:***	***Approval Outcome: Y N***
****Provider Agreement RD Signature Date***	***Date:***	
****Current Provider Agreement Begin Date:***	***Date:***	

Things to remember when completing these sections:

- The reviewer will enter the following:
  - Previous Provider Agreement End Date (on-going provider)
  - Current Provider Agreement Begin Date
  - Provider Agreement RD Signature Date
    - Enter the date the RD signs the Nebraska Service Provider Agreement, Provider Addendum (MC-190)
  - Date and approval status of each of the listed background checks
- Information about background checks should be found in N-FOCUS (refer to N-FOCUS training), or in the file.
- Various terms are sometimes used for the same background check, so reviewers should be careful to make sure to use the right information. (Example: The OIG check is sometimes referred to as the law enforcement check.)
- CONNECT will use the dates and background check information from this section to automatically answer the questions for this indicator.
- EPLS is also referred to as SAM.
- If there is not an approval date, the reviewer will enter the date the reviewer enters the file review and score a "no" for the approval outcome.

Indicator Questions for both Individual and Agency Providers:

Does the file document all 'Yes' approval outcomes?
Y N

Are the above dates on or prior to the RD Signature Date?
Y N

Is the current provider agreement begin date on or after the RD signature date?

Ongoing file only:

Is the current provider agreement begin date after the previous provider agreement end date?
Y N

Things to remember about these questions:

- Answers to these questions will be automatically filled in by CONNECT from the dates and background check information entered by the reviewer at the beginning of this indicator.

Remediation Action Options for Indicator 1D:

Individual Provider:

If no, provider agreement is ended immediately.
Complete and document required background information checks
Revise and improve local office provider approval process
Individual coaching*
RD waiver policy and procedure training*
Other (describe):

Agency Provider:

If approval outcomes marked no, provider agreement is ended immediately
Complete and document review of agency policies about hiring and reporting regarding abuse/neglect and criminal background
Complete and document review of Felony/Misdemeanor Statement
Revise and improve local office provider approval process
Individual Coaching*
RD Waiver policy and procedure training*
Other (describe):

Section B. 2. Monitoring Provider Service Provision

Applicable Waiver Sub-Assurance: The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies and contracted entities.
Applicable Waiver Performance Measure: Number and percent of waiver provider agreements correctly monitored by contracted entities.

2A. Does the file document that APS/CPS or Law Enforcement were notified when abuse and neglect was reported?

Does the file or N-FOCUS provider narrative documentation indicate that the provider was involved in an abuse and/or neglect incident?
If no, indicator is NA.
Y N

Things to remember when scoring this question:

- Assisted living staff are considered to be 'provider' staff.
- While the reviewer may find this information in the client file, the reviewer should find this information in the provider file. If the information is in the client file, but not the provider file, the item should be scored **'no'**.
- If this question is scored 'yes', additional questions will appear on the file review. If the question is scored 'no', the indicator will be scored NA and the reviewer will not answer additional questions for this indicator.

Was the incident reported to APS/CPS or Law Enforcement?
Y N

Does CONNECT contain an incident report for each occurrence?
Y N

Things to remember when scoring this question:

- Refer to CONNECT manual for instructions regarding incident forms.

***Remediation Action Options* for Indicator 2A:**

Narrative documentation added
Referral made to APS/CPS/ or Law Enforcement
Incident report filed with HCBS Waiver Unit
Revise and improve local office reporting process*
Individual coaching*
RD waiver policy and procedure training*
Other (describe):

2B. Does the file indicate monitoring activity was conducted when provider issues were identified?

Does the file or N-FOCUS narrative documentation indicate that follow-up occurred when provider issues (any breech of any provision of the provider agreement) were identified?
Y N NA

Things to remember when scoring this question:

- Provider issues may be found in the client file, but the follow-up needs to be in the provider file. So, if provider issues are found in client file, there should be follow-up in the provider file.
- This item is just measuring whether or not follow-up occurred. It is not measuring the quality of the follow-up.
    - If the reviewer has concerns about the quality of the follow-up, those concerns should be listed in the 'Comments' section.

If a complaint was received from a client/representative, was a CONNECT complaint filed?
Y N NA

Things to remember when scoring this question:

- Refer to CONNECT manual for instructions regarding complaint forms.

***Remediation Action Options* for Indicator 2B:**

Monitoring occurred to determine provider is fulfilling provider agreement standards.
Complaint report filed with HCBS Waiver Unit
Revise and improve local office reporting process
Referral to Program Integrity for claims recovery*
Individual coaching*
RD waiver policy and procedure training*
Other (describe):

Section C (Claims/Billing Review)

Claims Review

Getting started:

- The 'Review Month/Year' will be assigned by the HCBS Unit.
  - The sample month is 3 complete months before the month of the file review.
- All billings for waiver services delivered in the sample month will be reviewed.

Section C Heading:

Type of Review:

Date of Review:
Required Remediation Deadline:
File Review #:
Client's Name: ***Client ID:*** ***Waiver Type:***
Services Coordinator: ***Program Type:***
Resource Developer ***Review Month/Year:***

(Information listed above will be filled in by CONNECT. If information in this section appears to be incorrect, please contact the HCBS Unit prior to starting the file review.)

Check appropriate Provider claims:
In-Home (1A-1D only)
Assisted Living (1E only)
No Provider Claims

Things to remember when completing this section:

- The reviewer will check the appropriate type of provider claims.
- If there are In-Home or Assisted Living claims, additional questions will appear for the reviewer to complete.
- If there aren't any claims, the reviewer will be asked to complete the following section to document the reason why there aren't any claims.

If there were no claims for the month, indicate the reason for no billings and why no waiver services were provided:
Informal supports covered services
Service provided by provider has not yet billed
Not needed due to other paid supports
No provider available
Hospitalization of client
Reassessing client to determine continuation of Nursing Facility level of care
Other
Specify

Things to remember when completing this section:

- If the 'other category is used, the reviewer will need to specify what 'other' means.
- If there are no claims, there will be no questions and the reviewer can submit to finalize the review.
- Statewide data in this category will be analyzed by the HCBS Unit to help determine why clients are not receiving a monthly service.

Section C. *1. Financial Accountability*

Applicable Waiver Sub-Assurance: State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.
Applicable Waiver Performance Measure: Number and percent of claims paid appropriately (i.e., coded and billed).

In-Home:

1A. Were all in-home provider claims (N-FOCUS billing documents) properly filled out for the selected month?

General things to remember when scoring this indicator:

- This only refers to Waiver in-home provider claims. It does not include non-waiver Medicaid services such as Home Health.
- Per instructions for the N-FOCUS billing document, "designated service area staff or contractors review, approve (or adjust), sign and date copies" of claims forms.

Were the provider claims signed by the provider?
Y N

Things to remember when scoring this question:

- If there are multiple claims sheets/forms, they **ALL** need to be signed by the provider.

Were the provider claims forms reviewed and signed by SC, RD or designated staff?
Y N

Things to remember when scoring this question:

- Reviewer needs to look up the rates on the authorizations and compare them with all lines on each claim. **Any** mistake means the item will be scored **'no'**.
- Even though claims review can be time consuming, it's very important.
  - CMS looks at this.
  - Claims can also be looked at by the State Auditor. This is the same process the auditor would use.

Were the provider claim forms corrected, if necessary, to correspond with the N-FOCUS authorized rates and units?
Y N NA

***Remediation Action* Options for Indicator 1A:**

Provider training
Paid claim adjusted
Corrective action taken against provider
Refer to Program Integrity
Revise and improve claims review process*
SC/RD waiver policy and procedure training*
Other (describe):

1B. Did all in-home provider claims correspond with the N-FOCUS provider authorization?

Did the units claimed correspond with the units authorized in the Description page of the N-FOCUS Service Authorization?
Y N

Things to remember when scoring this question:

- Units should be equal to or less than the units authorized.

Did the rates billed correspond with the rate authorized in the Units and Rates Section of the N-FOCUS Service Authorization?
Y N

Things to remember when scoring this question:

- The rate should be equal to the rate authorized or within the range of rates authorized if the authorization contains a range.

***Remediation Action* Options for Indicator 1B:**

Provider training
Paid claim adjusted
Corrective action taken against provider
Refer to Program Integrity
Revise and improve claims review process*
SC/RD waiver policy and procedure training*
Other (describe):

1C. Did all in-home provider claims correspond with the "Individual Provider Record of Services"?

Did the services provided require an "Individual Provider Record of Services"?
If no, indicator is NA.
Y N

Things to remember when scoring this question:

- "Individual Provider Records of Services" are not required for Agency providers.

If yes, did the claims correspond with the units reported on the "Individual Provider Record of Services"?
Y N

Things to remember when scoring this question:

- Units on the claim should be equal to the units reported on the "Individual Provider Record of Services".

- A 'no' should be scored if there is any math error on any of the Individual Provider Records.

Are the tasks listed on the "Individual Provider Record of Services" allowed within the definition of the corresponding authorized service?
Y N

Things to remember when scoring this question:
- Make certain that the only tasks listed on the claim are those that are listed on the authorizations.
- Refer to the definition of the service for this item, not what's listed on the POSS.

Did the client sign to verify the "Individual Provider Record of Services" for each service authorized for each provider?
Y N

Things to remember when scoring this question:
- Client can sign with an "X" with a witness documenting that is the client's signature. The witness cannot be the provider.
- The client can also have someone else sign if that person has knowledge of the provided service. This cannot be the provider.

***Remediation Action* Options for Indicator 1C:**

Provider training
Paid claim adjusted
Corrective action taken against provider
Refer to Program Integrity
Revise and improve claims review process*
SC/RD waiver policy and procedure training*
Other (describe):

1D. For clients with multiple in-home providers of the same service, did the "Individual Provider Record of Services" for all providers document separate and distinct timeframes for services authorized for the client?

General things to remember when scoring this indicator:
- Again, this is time consuming, but needs to be looked at because both CMS and the auditor review this.
- HCBS Unit acknowledges that issues in this area may not always be identified immediately because billings don't always come in at the same time.
- The reviewer may need to utilize a monthly calendar to compare all timeframes to ensure there are not multiple claims for the same time period.

Does the client have multiple providers of the same service?
If no, indicator is NA.
Y N

If yes, do the files/"Individual Provider Record of Services" indicate no duplicate hours were claimed for services provided to the client?
Y N

***Remediation Action* Options for Indicator 1D:**

Provider training
Paid claim adjusted
Corrective action taken against provider
Refer to Program Integrity
Revise and improve claims review process*
SC/RD waiver policy and procedure training*
Other (describe):

Assisted Living (HCBS Unit Review Only):

1E. For Assisted Living Billings, were the billings coded and paid correctly as indicated on C-1 for the sample month?

General things to remember when scoring this indicator:

- The reviewer will need to access C-1 to determine information needed for this indicator. (C-1 screen shots and instructions for locating the needed information follow this section.)
  - The reviewer will need to have the following information in order to access the correct information in C-1.
    - Facility Provider Number (Will be found in CONNECT)
    - Client's Medicaid Number
- Rate information will be found on the 'Aged & Disabled Medicaid Waiver Assisted Living Rates' chart which may be found on the DHHS website.

For the sample month, does the claim match the number of days the person was in the facility?
Y N

Things to remember when scoring this question:

- This information is found on the **NURSIN HME TURN CLAIM** screen in C-1. A screen shot and instructions to locate this screen can be found later in this document.

Was the correct rate used for payment?
Y N

Things to remember when scoring this question:

- Reviewers will be able to determine whether the standard rate or the trust fund rate is to be used by looking at the 'Assisted Living Facility Type' in CONNECT. Instructions for accessing that information is in the 'Adding and Editing Waiver Assisted Living Providers' section of the CONNECT Manual.
- If there is doubt as to whether the standard or trust fund rate should be used, the reviewer may contact the HCBS Unit for information about the list of providers currently using the trust fund rate.

Was the Net amount billed to Medicaid determined correctly?
Y N

Things to remember when scoring this question:

- Examples for determining the net amount for both a partial and regular month can be found later in this document.

***Remediation Action* Options for Indicator 1E:**

Provider training
Paid claim adjusted
Corrective action taken against provider
Refer to Program Integrity
Revise and improve claims review process*

SC/RD waiver policy and procedure training*
Other (describe):